

**Authorization to Release Information**

I, authorize **Meagan S. Howard, MS, LPC** to disclose or release information from my records to the following person or entity:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information may be disclosed:

All Health Care Information

Initials

Health Care Information or Opinions Relating to any or all of the Initials following treatment(s) and, or conditions:

1) Psychiatric or Mental Health Information

Initials

2) Academic and Confidential School Information

Initials

3) Testing

Initials

4) Recommendations

Initials

5) Other

Initials

Emergency Contact Information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

Patient Date

Parent or Legal Guardian Date

Witness Date